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St. Bartholomew's Hospital Journal,

FEBRUARY 14th, 1898.

"Æquam memento rebus in arduis
Servare mentem."—*Horace,* Book ii, Ode iii.

NO one will dispute that the compulsory notification of infectious diseases was a step in the right direction. Most of the objections urged against it have been proved nugatory by experience. But we wish here to draw attention to a defect in the working of the Act, a side issue, accidental and not essential, and one for which its framers can hardly be held responsible. We allude to the question of the fees.

As everyone knows, the medical man who notifies is entitled to a fee of half a crown for each case in private practice, and one shilling for each case in hospital practice. Whatever the conditions may be in private practice, in hospital work it appears that these fees are by no means invariably forthcoming. Some will be inclined to retort that this is a very trivial matter,—a shilling is surely not worth troubling about. Perhaps; but let us remember that a medical man who fails to notify a case is liable to a fine of £2 10s. for each such failure. The responsibility of notifying in private is even more trying, as actions for libel have been commenced before now against an unfortunate practitioner for wrongly notifying a case as infectious. Considering, then, the risks which every medical man runs both in purse and reputation in connection with this Act, it behoves him to rigidly exact his fees. We have taken the trouble to analyse the notifications returned from this Hospital for the quarter ending January 1st, 1898. In that time 136 notifications were made by twenty-four different persons, and so far fees have been received for only 69 of these. We venture to assert that nearly all these have been received from four vestries, and that certain other vestries, who are earning for themselves an unenviable notoriety in the matter, have not sent a single fee.

The Public Health (London) Act, 1891, which regulates these matters, states, with admirable simplicity, that the Sanitary Authority "shall pay" the practitioner who forwards the notification. Two vestries at least, Whitechapel and St. Luke's, adopting the common-sense interpretation of this, forward the fees to some responsible person at the Hospital for distribution. Clerkenwell Vestry sends the fees to each individual; the Vestry of St. Mary's, Islington, improves on this by enclosing a stamped envelope for the receipt, but rather damages this generosity by sending the fee as a crossed postal order, a most tiresome form of payment. Some other vestries, among them being Lambeth, adopt the curious plan of sending a note to the effect that the fees will be forwarded on returning a receipt to them. But none of these methods are objectionable. The method we must distinctly protest against is the demand for an account from the medical man "that it may be examined and passed for payment." When he has gone through the counterfoils, how can he tell what are the boundaries of each particular vestry's jurisdiction? By sending such a demand they admit their liability. It is a piece of red tape

which is entirely uncalled for. As for the vestries who adopt none of these methods, but "keep on saying nuffin'," we do not profess to understand the principle on which they act.

Complaint without a suggestion for reform is valueless. We advocate, then, that the Resident Staff of this and other hospitals should insist that the fees be paid to some person at the Hospital responsible for their distribution. To the objection, *non possumus*, which may be raised by devotees of red tape, a simple and effective answer is ready to hand in the fact that this plan is already followed by at least two vestries. The present degree of subdivision, where twenty-four persons have each to deal with nearly a dozen vestries, is ridiculous. If our suggestion be followed, the game of "bilking" the medical man as played so merrily by Bumble at present, would come to a speedy termination.

A Few Remarks upon Adherent Pericardium.*

By SAMUEL WEST, M.D., F.R.C.P.

THE diagnosis of adherent pericardium presents many difficulties. In many cases there may be no symptoms whatever, and then of course the diagnosis cannot be made, unless from the previous history.

It is not at all uncommon in the post-mortem room to find the pericardium completely adherent in patients who have lived to a good old age, and who have never presented at any time symptoms of such a lesion, and in whom there is no history of any cause which could have produced it.

In the same way, in a patient who has passed through an attack of acute rheumatic fever, in the course of which severe pericarditis had occurred, all the symptoms may gradually disappear, and the physical signs return to the normal, and the patient remain in good health for years without any cardiac symptoms. The question in such a case would arise whether the pericardium was adherent or not.

How far complete recovery can take place after an acute attack of pericarditis must remain a question of opinion, but on the whole the chances of it are much less than in the case of pleurisy, and we know well how frequently a slight attack of pleurisy leaves adhesion behind. I suppose we may, at any rate, assume that in cases where there has been suppuration in the pericardium, the two layers of the pericardium will subsequently adhere, although I do not know that this necessarily follows as a matter of course. Yet in the case of suppurative pericarditis that I recorded, now many years ago (nearly eighteen), after the sac had been incised and drained, the cavity of the pericardium was completely obliterated in the course of a week. The patient got quite well. I have frequently seen him since, the last time about a year ago. He had grown a big man, and was in perfect health; there were no physical signs whatever, except the scar over the seat of incision, which would show that there had ever been anything whatever the matter with his heart. He was apparently in perfect health, yet I can hardly suppose that the pericardial sac has not been completely obliterated.

Usually the diagnosis of adherent pericardium is made in some such way as follows:

The patient, who has some symptoms of cardiac disease and some physical signs of a lesion—let us suppose those of mitral disease following rheumatic fever,—presents certain other peculiarities, especially in the shape of the heart, and possibly in some other physical signs, which show that the case is not one of simple mitral disease alone. Something else is required to completely explain the condition, and that something very often turns out to be an adherent pericardium,—at any rate, the diagnosis thus made is often confirmed subsequently if an opportunity for post-mortem examination presents itself.

Systolic recession of the apex-beat is given as a pathognomonic sign very frequently in descriptions of adherent pericardium. I think it is pathognomonic when present, but it is far more often absent. It requires for its production certain peculiarities which are not likely always to concur; for the pericardium must not only be adherent, but it must have formed adhesions both to the chest walls in the region of the apex, as well as to the mediastinum behind. This latter lesion is an essential part in the production of the phenomenon; for the apex-beat in health is due to the elastic recoil or spring of the aorta when the blood is driven into it during systole; if, however, the base of the heart be fixed, so that this recoil of the aorta cannot make itself effective, as the heart shortens on systole the apex will be drawn up and in, and thus the phenomenon produced.

In adherent pericardium it is not the obliteration of the serous sac which is the only, or indeed the most important lesion. The fibrous part of the pericardium is in direct continuation on the outside with the fibrous tissues of the mediastinum, and over the heart with the intermuscular connective tissue.

If the two layers are adherent, but the inflammation has not spread in either direction, then it really makes very little difference whether there is a real pericardial sac or not; for a pseudo-pericardium, as it may be called, is established in the loose mediastinal tissues, so that the action of the heart is not impeded. If, however, the mediastinal tissues are thickened, and the heart closely bound down to the sternum and chest walls, the movement of the heart must necessarily be very greatly impeded; the heart will be prev.nted to a

* Made in the course of a debate upon this subject at the Medical Society, in January, 1898.

great extent from emptying itself; it will rapidly fail, and present the signs, after death, of dilatation.

In a similar way, if the inflammation spreads from the pericardium along the fibrous intermuscular bundles into the substance of the heart itself, a condition will be produced very similar, for example, to that of cirrhosis in the liver; the effect upon the soft muscle bundles will be the same as that upon the soft liver cells, and they will degenerate and atrophy. In such a case symptoms of cardiac failure appear very early.

In chronic cases a considerable amount of thickening and induration may take place in the heart substance, which may give the appearance of hypertrophy, but in some of these cases the hypertrophy, as it is often called, is not a real muscular hypertrophy at all, but a spurious hypertrophy largely due to the increase of the interstitial connective tissue.

Partial or irregular lesions of the pericardium sometimes give rise to very puzzling and difficult physical signs when a second effusion takes place; thus there are some strange cases recorded, in which pockets containing pus or serous fluid have been found in a partly obliterated pericardium.

Adherent pericardium is no doubt, in the great majority of cases, of rheumatic origin. Sometimes it may arise in the course of other infectious or septic fevers, or be the result of the spreading of the inflammation to the pericardium from the neighbourhood,—as, for example, after pneumonia or pleurisy.

Irregular adhesions at the base of the heart may produce very odd symptoms sometimes; thus I have seen, as the result of a pleurisy, the vena cava almost completely occluded and symptoms of venous obstruction produced, of which the cause was very obscure during life, and undiagnosable.

Tubercle and gumma seem to be the cause occasionally of pericarditis, and so, of course, may be also malignant disease in the mediastinum, but these affections partly belong to the same category.

To account for some of the cases in which no cause can be ascertained for an adherent pericardium, it must be borne in mind that acute or subacute pericarditis may be observed without any symptoms at all pointing to it; it may be discovered by accident, as it were. This occurs most frequently with granular kidney or gout. I have seen several instances of this, and if a careful routine examination of the patient had not been made, the condition would have been overlooked. In granular kidney, post-mortem examination shows that adherent pericardium is by no means very rare.

It is remarkable that in some cases of chronic pericarditis the friction may continue to be heard for a great length of time—weeks or months—long after all symptoms have passed off. I have observed this myself in a few instances.

Some Rectal Diseases.

By F. C. WALLIS, M.B., F.R.C.S., Assistant Surgeon Charing Cross Hospital and St. Mark's Hospital.

I.

ANAL PRURITUS, ANAL FISSURE, SIMPLE RECTAL ULCER.

FISSURES or ulcers are so often the exciting cause of pruritus ani (more especially ulcers), that I have thought it better to consider these three disorders in a group.

Anal pruritus is one of the most persistent and wearying of the various disorders which afflict the lower end of the alimentary canal.

The main feature of the disorder is the intense itching of the parts, which is most marked at night-time, when the patient is in bed. The results of the constant scratching are very soon made apparent on the tissues, which become inflamed, raw, and unusually moist, especially where the buttocks are in apposition.

In chronic cases the epidermis is thickened and sodden, and frequent cracks occur in the skin surface, particularly in the post-anal line, or at any part of the anal circumference on the muco-cutaneous margin.

A certain amount of stress has been laid on the fact that in old-standing cases patches of skin become changed in appearance to a dead white colour, and to the touch more like scar tissue than normal skin.

This is the ordinary pathological sequence of chronic inflammation, the effect of which is to replace most of the elements of the true skin with fibrous tissue. It may be seen in the skin in any other part of the body where chronic inflammation has been, or is existing.

The condition of the parts may vary considerably from the above, and the variation depends upon the particular cause of the pruritus, or upon some co-existent local trouble, such as eczema, eczema marginatum, pediculi, &c.

Causes.—The causes of pruritus are constitutional and local, and not infrequently a slight local cause will lead to a bad condition of pruritus, because of some predisposing constitutional condition. It is always well to bear this in mind in treatment, and I quite agree with Allingham in what he says on this point.

Errors of diet, especially in gouty people, or in those who are prone to secrete an excessive quantity of uric acid, are the commonest causes of the *persistence* of cases of pruritus.

At St. Mark's Hospital I invariably ask three questions —(1) How much beer? (2) When do you have supper? (3) When do you go bed?

The answer to the first question is, of course, vague, but it is usually found that beer, in the abstract, is drunk during the evening, particularly at supper, and that the supper is often a late and a hearty one. The patient retires to bed

within an hour. Washing in general is rather rare, and locally almost unknown.

In patients of a better class it will be found that some particular article of diet is apt to produce pruritus, and when this is discontinued the pruritus, if treated with some local application, will soon cease.

As examples of this I may quote two instances. The one, a patient who was a most careful liver, came to see me about a condition of quite bad pruritus. Knowing him to be careful, I could not find out any dietetic indiscretion until when dining with him I noticed he drank a quantity (three tumblers full) of ordinary claret, and I elicited from him that he usually took almost as much at luncheon. This was discontinued, and the trouble disappeared in a very short time.

The other case was somewhat similar, in that the patient, who was gouty, indulged in an imperial pint of champagne every night at dinner. After much persuasion this was discontinued, and a rapid cure was the result. Coffee, tea, tobacco, various forms of shellfish, &c., are all possible causes of pruritus.

The difficulty in dealing with general causes is to get the patient to do what he is told. More often than not the offending article of diet is one to which the patient is particularly attached, and which he consequently gives up only after a struggle.

Strumous people with delicate skins and a great deal of hair locally are apt to suffer from pruritus, especially when somewhat "run down."

The neurotic element must not be forgotten in these cases. People of sedentary occupations, who are overworked and are of this temperament, are liable to attacks which are sometimes most difficult to cure.

Local causes of pruritus are fairly numerous. Constipation, hæmorrhoidal congestion, hæmorrhoids, polypi, fissures, fistulæ, oxyuris vermicularis, and simple ulcers are causes inside the bowel.

Causes outside are eczema, eczema marginalis, pediculi, excessive sweating; lastly, and amongst hospital patients mainly, want of washing.

Most of the local internal causes speak for themselves, producing from congestion or discharge a condition of local irritation, which if not attended to soon produces a well-marked condition of pruritus ani.

There is one of these causes, viz. the local solitary ulcer, to which I wish to draw particular attention.

A few months ago we had quite a number of pruritus cases hanging on in the Out-patient Department, and in spite of all sorts of treatment they remained much as they originally were. I carefully explored the rectum in each case with the finger, and then with the speculum and a small electric lamp which I could introduce into the rectum. In more than 25 per cent. a small ulcer could be felt situated dorsally between the two sphincters or a little higher. This condition was confirmed by the speculum and electric light.

Since then, Mr. Cudmore—the house surgeon—and I have examined each case of pruritus by this method, and the percentage of these ulcers continues certainly as high, if not higher than that mentioned above.

It is curious that the frequency of this cause should have been overlooked by other observers, but I hope now attention has been drawn to the fact that the experience of others will be forthcoming.

Treatment.—Treatment in these cases must be local and general, and will vary greatly according to the social position of the patient.

In Charles Dickens's "Little Dorrit," an Italian, out of gratitude to some Englishman for having saved his child's life, asked what he could do to prove his thankfulness, and the Englishman's answer was "wash a little more." This might with profit be repeated as a sort of litany to most hospital patients suffering from pruritus; perhaps "wash a *great deal* more" would be better still.

This sanitary measure, combined with a strict diet, discontinuance of beer drinking, and some saline purgative, will go a great way towards curing most cases, which are, or were originally, constitutional in origin. I find that bran baths, especially at night-time, are most beneficial. A large double handful of bran put in a gauze bag and placed in the bath ten minutes before the patient sits in it is the simplest way of procuring this. A small amount of pearl-ash may be added to the bath water, which should be as warm as can comfortably be borne by the patient. The bath should last for twenty minutes, the buttocks should be separated as far as possible, and this is best done by placing the bran bag between them. Afterwards the parts should be carefully dried, and dusted with a powder containing equal parts of oxide of zinc, starch, and boric powder; the buttocks are well separated by a firm pad of cotton wool, which should be kept applied closely by means of a T-bandage, and should be worn at night-time. The bath may with advantage be repeated in the morning, and a strip of lint, spread with boric ointment, should be kept in position during the day by a pad and bandage.

If some parasite is the cause, the treatment will be to get rid of it by the usual well-known methods.

Hæmorrhoids, fissure, fistulæ, &c., causing pruritus must be dealt with before a cure can be hoped for.

If none of these exist, look for the solitary ulcer mentioned above; if this is overlooked, a cure will not be brought about. If this is present, the best and most rapid method of dealing with it is to stretch well the sphincters under an anæsthetic, scraping the ulcer at the time if it is thought necessary to do so.

Two cases where this was done are related in Cooper and Edwards' book, but the presence or absence of the ulcer is not stated.

It will be seen from the above remarks that although pruritus ani is easily diagnosed, the cause may be quite difficult to ascertain, and the cure still more difficult to obtain.

A careful examination is most essential, and if this is made, and the patient given to understand that it is only by strictly adhering to the treatment for possibly quite a length of time that a cure can be effected, success will be met with in nearly every case. But it is necessary that the patient should be made to fully appreciate that the disorder does not always yield readily to any form of treatment.

Anal fissure, although a very slight local lesion, is one of the most distressing complaints that a medical man has to deal with. Against this, however, may be set the fact that the treatment is a certain cure, and usually permanent.

The cause of the unusual and continuous daily pain of a fissure is really its locality. Muco-cutaneous margins are all extremely sensitive and plentifully supplied with nerves, and the anus is no exception to this. It is quite curious what a difference there is in the painful symptoms in various cases; and it depends entirely upon whether the ulcer or fissure is actually on the sphincter or just inside it. Fissures which are on the sphincter, and can be readily seen upon separating the buttocks, are those which cause the most pain, amounting in some cases to real agony, lasting for many hours. Those which are situated a little higher, and can only be seen when the muco-cutaneous margin is put on the stretch, do not give rise to the same amount of pain, and the paroxysms are not so long-lasting.

Fissures are produced in the first place by the contents of the bowel causing some lesion during the act of evacuation. This lesion is generally situated in the mid-line posteriorly, but may occur at any other part of the anal circumference.

When the fissure is due to a simple crack in the muco-cutaneous margin its appearance is very much like that seen in a badly "cracked lip," but when the lesion is due to one of the small anal valves being torn down the appearance is quite different. In these cases the first thing that presents itself is a small tag of œdematous skin, which Van Buren has called the "sentinel pile;" if this tag is pulled back a shallow ulcer is seen immediately on the other side of it, and in these cases the floor of the ulcer is generally unhealthy in appearance.

This is one of the very few surgical troubles where a patient willingly submits to—almost asks for an operation. The reason, of course, is the daily bitter pain that has to be gone through.

Before I deal with the treatment, which is quite simple, I wish to urge that *no delay is permissible*. The two following cases tell their own tale, and confirm my statement.

E. G—, a girl æt. 18, came to my out-patients at St. Mark's on September 16th, 1896. She had pruritus ani and a fissure, for which she was given some medicine and ointment, and her name was put down to come in as soon as possible. She attended once after that, and then her mother came up asking for medicine, saying the girl was too ill to move. On inquiry it was considered advisable to get the patient to the hospital, and she was brought in a cab in the course of an hour. It was at once evident that the girl was extremely ill. Temp. 103°, quick pulse, furred tongue, and anxious expression.

On examination a large bilateral ischio-rectal abscess was found with wide-spread inflammation of skin. Pus of the most foul odour escaped from the bowel. The abscess was opened on one side and the tension relieved there and then, and the girl came into the hospital, where two days later the abscess was very freely opened, and a complete rectal examination made under an anæsthetic. A large internal opening was discovered well above the internal sphincter.

The patient was discharged on November 23rd, 1896; readmitted in February, 1897, for a fistula—the remains of the large abscess,—and was discharged cured on April 3rd, 1897, the whole treatment going over a period of six months.

The other case was that of a man æt. 49, who attended the out-patients' department for a fissure for about three weeks previous to his admission on February 20th, 1897, when he came to the out-patient's department with an enormous ischio-rectal abscess, which was at once freely opened; a sinus ran up alongside the bowel for nearly six inches. The patient was sent to the wards. Temperature on admission was 101·6°, but normal next day. On February 26th temperature began to rise, until March 1st, when it reached 103°. On this date a collection of pus at the upper end of the sinus burst into the rectum. The temperature came down gradually to normal. On March 8th I operated on him, laying the whole sinus and track freely open from the outside. There was a large internal opening high up. The wound was packed for a few days and then fomented.

From now, on, the man made a steady recovery, the internal opening healing up with the gradual contraction of the wide external operation wound. He was discharged well on June 5th, 1897, having been in hospital four and a half months, and has remained well ever since.

These two cases well illustrate that there is serious danger, over and above that of the daily pain, in allowing these fissures to go unrelieved.

The sequence of events in these two cases I take to be as follows:

On account of the pain which follows the daily evacuation, patients put off the evil moment as long as possible. The lower bowel becomes loaded with most septic material, which starts by infecting the fissure and so getting into the subcutaneous tissue. Very soon the ischio-rectal fossa falls a victim, and here, owing to the peculiar conformation of the fossa, a large amount of pus may accumulate before

any signs of tension make the patient feel that it is necessary to "see some one." By the time that point is arrived at the whole of one or both fossæ may be tense pus sacs, and, as happened in both the cases related above, the bowel may give way high up. In the cases quoted both these internal openings closed, but it is not the fortune of most cases to have such a good result.

Now, as regards treatment of fissure, there is only one which can be relied upon as curative, and that is division of the whole, or better still, part of the external sphincter. This may or may not be accompanied with stretching of the sphincter, but I do not consider it necessary. Merely stretching the sphincter alone may cure it, but it may not. The reason of this is that although sphincter paralysis is produced by the stretching, it does not exist long enough to allow the fissure to heal; therefore, although there is temporary relief, after a time all the old symptoms may recur, to the great exasperation of all parties concerned.

During the last few months I have adopted the following method in the out-patients' department at St. Mark's:

The patient being in the knee-elbow position, the buttocks are separated, and the fissure and surrounding parts are well washed with 1 : 500 perchloride solution; then a 4 per cent. solution of eucaine is injected in the manner I suggested in a former paper. An incision is now made commencing at the external limit of the fissure, and going straight back for three quarters of an inch to an inch, completely dividing whatever part of the sphincter is underneath it. By this incision spasm of the sphincter disappears, and the contraction of the muscular coat of the bowel—particularly the internal sphincter—draws the ulcer into the bowel out of harm's way, so to speak.

The incision is plugged for twenty-four to thirty-six hours, and the patient is given strict injunctions with regard to cleanliness and the application of 1 : 500 perchloride solution locally. Some slight laxative is ordered, and the patient is seen on the fourth or fifth day. Nearly twenty cases of fissure have been so treated now by Mr. Cudmore and myself. No bad results have occurred, and I have not heard of any case so treated which has not ultimately got well.

This treatment may be considered somewhat risky. My reason for trying it was because of the number of men who were waiting for admission and had to go on, week in, week out, with no relief, or only the slight relief which palliative treatment affords.

If a patient carries out the instructions given him there are no risks; all pain is relieved, the fissure gradually heals, and—Saturday being the day for the treatment—he is able to lie up until Monday and resume work on Tuesday. This last fact is an important one to busy men in all stations of life.

Simple ulcer of the rectum I have found to be quite a common complaint. It is usually associated with pruritus ani, and when this is not present the patient complains of a dull aching or dragging pain, and a burning sensation lasting for some time after evacuation. These are usually the symptoms complained of. The cause is the same as that mentioned for fissure.

These ulcers are usually single, and nearly always situated dorsally, between the sphincters, not interfering, at all events, with the external one. They are not easy to discover by examination unless one's finger has had some practice, but after a few examinations have been made there is no difficulty. They can be seen with the speculum, and look livid in colour as compared with the pink colour of healthy mucous membrane. When seen by this means they appear to be much higher up the bowel than they really are, because the tissues are pushed up by the speculum.

Patients go on with these ulcers for a very long time without seeking relief. The ulcers remain stationary, and show no inclination to either heal, spread, or multiply.

Women suffering from this are often treated for uterine or ovarian troubles, and men have been treated for prostatic disease, and a calculus has been diagnosed.

These ulcers are difficult to cure by any palliative treatment,—in fact, I think one may say the majority of them are not to be cured by these measures. Mercurial ointments, nitrate of silver in solution or applied in the solid form, may be tried, but disappointment is more often the result than not.

The best treatment is to dilate the sphincter well, and to scrape the surface of the ulcer, which rapidly heals after this, provided that here, as in all cases of rectal surgery, scrupulous surgical cleanliness is maintained.

(*To be continued.*)

On Appendicitis.

A Paper read before the Abernethian Society on November 4th, 1897,

By T. P. LEGG, M.B., F.R.C.S.

(Continued from page 51.)

DIAGNOSIS.—Nothing may be more easy, and nothing may be more difficult to diagnose than appendicitis. It is those cases where the history points to rapid onset and development of the symptoms in which the difficulty arises. Cases where the patient is obviously very ill, with distended abdomen and nothing much to be made out on examination, are the ones which give rise to grave mistakes and fatal results. In all such cases remember two things, the value of an examination under chloroform, and "in all cases of doubt, think of the appendix." Under chloroform a definite mass or induration may be felt in the right iliac fossa, which before was not evident, leading to a correct diagnosis, and saving the patient's life, or at least giving him a chance. Moreover, this may prevent the discovery post mortem of a localised abscess, which if drained would have saved him. The history is of importance,—a history of previous

attacks or pain with constipation which may have only lasted a few days, and scarcely caused inconvenience. The age of the patient is of some value, more especially in helping the diagnosis from mechanical obstruction, though the appendix may here be at fault, causing the obstruction by bands of adhesions. From acute intestinal obstruction due to other causes the diagnosis may be impossible till the abdomen is opened. In these cases, however, the vomiting is more profuse and stercoraceous, the constipation both of fæces and flatus more absolute, and localised tenderness usually not present. But, even so, when the abdomen is opened in the middle line, examine the iliac regions carefully for induration, and still think of the appendix.

In intussusception we have the passage of bloody motions, tenesmus, and the characteristic tumour.

Perforated gastric ulcer has been diagnosed for appendicitis, and the abdomen opened and nothing found wrong with the stomach. Such a case is reported by Mr. Page in the *Lancet*, 1895, vol. i. At the post-mortem a circumscribed abscess due to perforation of the appendix was found, and no general peritonitis. The patient was twenty-one years old, and had been ill fourteen days.

Tuberculous peritonitis and tuberculous ulceration of the cæcum have been mistaken for appendicitis. Such cases have been reported by Mr. Lockwood in the *Clinical Journal*, and Mr. Page in the *Lancet*, July 3rd, 1897. In the early stages renal colic has been diagnosed for appendicitis; the symptoms being frequent micturition, pain on micturition, and along the course of the ureter, as well as localised tenderness, most marked in the loin and kidney region.

Typhoid fever is another disease which not infrequently has led to error. There was such a case in the hospital this summer, and it was only at the post-mortem that the true nature of the illness was found out. It was then found to be a case of general peritonitis due to a sloughing appendix, with multiple abscesses throughout the whole body—in fact, general pyæmia.

Other diseases to be borne in mind are gall-stone colic, perinephric abscess, pelvic abscess, psoas abscess, cancer of the cæcum, constipation, and the hysterical appendicitis of French surgeons (*Lancet*, 1896).

In women, abscess due to the appendix has been diagnosed as due to disease of the ovary or Fallopian tube, and in children hip disease on the right side has been diagnosed when the appendix was the cause of the symptoms. Finally, it must not be forgotten that all the symptoms of acute general peritonitis may be simulated by a localised abscess.

Prognosis.—The prognosis of appendicitis is not easy to determine, and it has to be considered in relation to the chance of recovery and chance of relapse.

In any given case it is not only difficult, but often impossible, to say whether the patient will die or recover. For those cases in which the onset is gradual may and do end in general peritonitis and death; and those cases in which the onset is acute, and the patient desperately ill, end in complete recovery.

As far as I can make out, the general mortality in hospitals is 14 or 15 per cent. Treves says, taking all cases together, the mild and most serious, the mortality is about 5 per cent. In connection with hospital statistics many of the cases, it must be remembered, are hopeless on admission.

The most rapidly fatal cases are those where the signs of general peritonitis are the first symptoms of the illness.

As to relapses, Hawkins says that of 250 cases admitted to St. Thomas's, 23·6 per cent. gave a history of one or more previous attacks. Fitz put it as high as 44 per cent., and Greig Smith from 33 per cent. to 40 per cent. There is nothing about the first attack which will enable one to say whether there will be a second, unless it goes on to abscess, and age makes no difference. The separate attacks may vary in degree enormously; they may lay the patient up for weeks or only a day or two, but in the intervals he is quite well, thus distinguishing it from chronic appendicitis. There is no limit to the number or frequency with which they occur.

Complications.—As to complications, one has only time to mention one or two of the most important, and which give rise to after trouble. The first is fæcal fistula; the opening of the fistula is usually in the right iliac region, over and communicating with the cæcum; in other cases it opens in the loin or at the umbilicus, or. if the abscess has burst internally, into the organ affected. They last a very long time in many cases, but in the majority they show a disposition to close spontaneously under careful dieting and attention to the bowels. In other cases they heal up rapidly as soon as the abscess heals. They are very difficult to cure by operation.

The second complication is ventral hernia. Treves says they occur in less than 5 per cent., and most commonly in abscess cases where a large incision was made and not partially sewn up. The best way to prevent their formation is to sew up the wound layer by layer,* keep the patient on his back till it is soundly healed, and give a slight support or truss if necessary.

Other important complications are intestinal obstruction due to kinking of the intestines by adhesions, or adherence of the inflamed and sloughing appendix to the intestine; two or three such cases have been in the hospital during the last five years.

Abscesses of the liver, subphrenic abscess, and pylephlebitis have not unfrequently been found, and in most of the cases a fatal result has occurred; they are obviously pyæmic.

Treatment.—Absolute rest in bed is most essential till all the acute symptoms have disappeared and the local signs subsided. Every case, however mild, should be so treated, as one cannot foretell what course will be taken.

The diet should be of such a kind as to leave little débris. Whey alone is given by some physicians; milk should be given boiled, and well diluted with barley or plain water. If it causes sickness it should be given peptonised, and always at definite intervals and in stated quantities; if necessary, rectal feeding should be used; beef tea, broths, and eggs may be given. Locally the weight of the bedclothes should be removed, and hot fomentations with or without belladonna or opium applied; leeches relieve the very acute pain.

Internally opium should not be given as a routine thing, and if possible avoided; when necessary it should be given in the smallest doses required to produce the desired effect, viz. to relieve pain and put the bowel at rest; morphia hypodermically may be required, and belladonna is recommended by many. Evacuation of the bowels is best obtained by enemata.

The prevention of relapses.—(1) Correct all digestive disorders; take food at regular hours, and such food as is easily digested; eat it slowly, and have the teeth attended to if not in good condition.

(2) Have the bowels open daily, using an aperient or enema if necessary.

(3) Treves recommends massage of the abdomen, and some intestinal antiseptic such as salol night and morning.

(4) Violent physical exertion and exposure to cold are to be avoided; gentle exercise is beneficial.

The question of operation.—First, as regards relapsing cases. This operation was first proposed by Treves in his paper read before the Royal Medical and Chirurgical Society in 1888. He there describes his first case, in which the appendix was not removed but freed of adhesions, the patient recovering completely. In the same paper he recommends removal of the appendix in the majority of cases.

The questions then arise—in what cases, and when, should the operation be done?

The time when the operation is to be done is, without doubt, during the quiescent stage, when all acute symptoms have subsided, for if not, troublesome and severe hæmorrhage may occur; besides, the appendix may not be found, and the risk of infecting the peritoneum is increased.

Each case must be separately considered. Most surgeons advocate removal after two well-marked attacks, and probably this may be right considering all cases; but the facts of the case should be pointed out to the patient, and the risks he undergoes by not having the organ removed. It should be pointed out to him that at any time he may get a very severe attack, and death result. But even so one must consider his station of life—whether he is able to spare the time, and nurse each attack properly. Next, the age of the patient should be taken into account; the younger, the more the operation should be urged, for the attacks are likely to go on, and the risk is less than in adults.

Operation should be urged in all cases where the attacks are frequent or have been numerous, when the last attack was severe, when the patient has to lead an invalid's life or is prevented from following his employment, and when the local signs are persistent during the quiescent period.

Method of operating.—Most surgeons use an oblique incision, about two inches long, parallel to the outer part of Poupart's ligament, about two inches from the anterior superior iliac spine; the objection that is made against this incision is that much muscular tissue is divided, and a ventral hernia liable to result. In certain cases this does happen, but the risk can be reduced to a minimum if the muscular fibres are separated rather than divided, and the layers

* This method of sewing up the wound refers to those cases operated on for removal of the appendix in relapsing cases. Where the wound is not quite aseptic, buried sutures are not advisable; but even in such cases all the layers can be approximated by single sutures.

of the abdomen be sewed up separately, and rest in bed enforced till the scar is firm. Besides, this incision is the one placed nearest to the appendix. Two other incisions are made by some—one in the middle line below the umbilicus, and the other obliquely, parallel to the linea semilunaris and midway between the umbilicus and anterior superior iliac spine; the rectus is exposed, and pushed to one side. In sewing up the wound, special care is taken to reapply the rectus to its natural position and in stitching the separate layers of the abdomen and the margins of the cut aponeurosis. It is said that the appendix is more readily reached than would seem likely, and the risk of hernia practically none.

All adhesions, except very recent ones, must be cut and not separated by tearing. The cæcum being found, the longitudinal band on its surface is looked for and traced downwards; the gut is drawn out of the abdomen with the appendix, and the general peritoneal cavity shut off by sponges. The appendix is clamped as close to the cæcum as necessary, usually about half an inch away, and the mesentery transfixed by two or more silk ligatures, which are tied; then the appendix is cut away from the mesentery, and its peritoneal coat divided circularly as well as the muscular; the mucous membrane is drawn out and cut off. This procedure cannot always be carried out, on account of previous inflammation. In such cases divide it right across. The stump is then disinfected by touching it with the actual cautery or applying pure carbolic acid; dust on iodoform, close the mucous membrane by two or three fine silk sutures, and then stitch the peritoneum up over the mucous membrane, so as to give the stump a complete peritoneal investment, using Lembert's suture. If the peritoneum cannot be closed over, make a graft of peritoneum from an adjacent piece. After irrigation the wound is closed as described, and no drain is necessary.

The operation may be very difficult owing to the adhesions, which may be so dense as to prevent the appendix being found, or that organ may be very closely adherent to the cæcum.

Treves recommends that the incision should not be placed directly over the dullest part or the line of the appendix, as here the adhesions are densest.

The mortality of the operation is very small. Treves has done 150 cases with one death. Last year it was removed eight times with no deaths in the hospital.

As regards operation in acute cases, widely different opinions are held as to when it is to be done; one class of surgeons operate quite early, and the other class wait, watching symptoms. Many surgeons say that if the signs of pus are present, operation should be done at once; others, in the absence of specially urgent symptoms, wait from day to day on the ground that the pus is at first not well localised, and may be deeply situated so as not to be found without infecting the general peritoneal cavity, or at any rate breaking down existing adhesions and increasing the risk to the patient. It has already been mentioned how difficult it is to diagnose the presence of pus, and some American surgeons strongly advocate the use of the exploring syringe in such cases; one of them, Weir, advocating its use in several places, "particularly a deep hypogastric puncture into the pelvis." This is a practice not to be recommended in any case. A very much safer and better plan is an incision.

If the symptoms point to general peritonitis, immediate operation should be done, the incision being first made in the middle line, and the cavity examined; if no peritonitis is found, the wound is closed before operating on the appendix.

Now, suppose an abscess is present, the first and main thing to be done is to open it and let out the pus. The incision is best made parallel to and slightly above Poupart's ligament, and below the anterior-superior iliac spine. This is the best and most direct way of draining the abscess. An incision in the right linea semilunaris is bad, inasmuch as the pus is not directly reached and evacuated; further, the risk of opening and draining the abscess through the general peritoneal cavity is increased. For similar reasons a median incision is much less satisfactory.

Having let out the pus, I think all the surgeons here do nothing more in most cases. From my own experience washing out is not necessary, as the discharge will be sweet in twenty-four hours, or at any rate plain water at low pressure is all that is necessary; further washing out is not without risk, and it is impossible to make the abscess cavity aseptic, and in no case must the walls be scraped.

The incision should be free—it may be easily sewn up afterwards. Some surgeons advise examination of the abscess cavity to note whether the appendix can be seen, and if so whether it can be removed; of course, if it lies loose, or nearly separated, and can be removed without breaking down adhesions, remove it by simply placing a ligature round it and cutting it off; nothing further in the way of an elaborate operation can be done; persistent attempts to find it by breaking down adhesions are not advisable. This, however, is the point on which surgeons widely disagree. American surgeons deliberately break down the adhesions, pack sponges in the wound, and remove the appendix. Mayo Robson says, "if the adhesions be broken and the general peritoneal cavity opened, no harm will result if the parts be isolated by sponges; on no account should a prolonged search be made." Last year at this hospital, in thirteen cases of limited incision and no removal of appendix (all acute cases), ten recoveries were the result; and in two cases the appendix was found easily and removed, and both recovered.

If on opening the abdomen pus is found but not localised, should the appendix be sought for and removed, or should a drain be put in and nothing further done? Last year seven cases were operated on in which the peritoneal cavity was opened and washed out, and the appendix sought for and removed; three lived and four died, in all there was general peritonitis, and the question arises whether this resulted from or was present prior to the operation? In some it was apparently present at the operation, and in others it appears to have been absent.

As regards washing out, the length of time for which it can be done depends on the condition of the patient; some improve under it, but rarely is prolonged irrigation borne well. Many surgeons sponge out the cavity, and do not wash out at all, particularly the lumbar regions and pelvis; into each of these a drainage-tube is afterwards placed and left in twenty-four to seventy-two hours, according to circumstances; this is, perhaps, the better method. Of chronic appendicitis with suppuration, six cases were operated on last year by limited incision through the adhesions. In no case was the appendix sought for, and all recovered.

It is not possible to lay down any definite time when operation should be done, but the longer it can be delayed, probably the better; in most cases it would not be called for before the third day at the earliest, and generally not earlier than the fifth day. Cases which end fatally in thirty-six to forty-eight hours are rare, and most of them hopeless from the outset; still, if the diagnosis be made their only chance is operation.

Then it is also argued that the abscess is liable to burst into the general peritoneal cavity; as a matter of fact, eight out of sixty-seven cases (Dr. Bull) took this course. A small collection of pus may be deeply placed and not found, whilst the general peritoneal cavity becomes infected in the manipulations necessary at the operation.

The more the abscess is localised, the better the chance of recovery.

To sum up, all the symptoms of general peritonitis may be simulated by a localised abscess, and the onset of a non-suppurative case may be most acute, so that early operation should not be considered necessary in such cases—each must be considered separately. There is one set of cases, however, where an abscess has been known to exist and burst internally; in these cases immediate operation is essential. In all cases the appendix should not be sought for by a dissection or the adhesions broken down.

TABLE SHOWING NUMBER OF CASES ADMITTED TO THE WARDS OF ST. BARTHOLOMEW'S HOSPITAL DURING THE YEARS 1892-6.

Year.	*Medical Wards.*	*Surgical Wards.*
1892	34	5
1893	23	7
1894	30	11
1895*	19	15
1896*	23	53
Totals ...	129	91

Totals for 5 Years.		*Males.*	*Females.*
Medical Wards,	129	99	30
Surgical „	91	76	15
Total ...	220	175	45

Proportion of males to females attacked, 3·8 to 1, *i.e.* nearly 4 males to 1 female.

Percentages.—Males, 79·5; females, 20·4.

* In these years several cases of abscess were admitted to the Medical Wards, which I have here included in the Surgical Wards as they were transferred and operated on.

TABLES SHOWING THE FREQUENCY OF APPENDICITIS AT DIFFERENT AGES OF CASES ADMITTED TO ST. BARTHOLOMEW'S HOSPITAL DURING THE YEARS 1892–6.

Cases admitted to the Medical Wards.

Age.	1892	1893	1894	1895	1896	*Totals.*
0–5	—	—	—	—	—	—
5–10	2	3	3	2	—	10
10–15	8	5	5	4	5	27
15–20	9	2	8	5	6	30
20–30	9	9	11	4	4	37
30–40	4	1	2	3	4	14
40–50	—	3	—	1	4	8
50–60	2	—	1	—	—	3
Totals	34	23	30	19	23	129

Cases admitted to the Surgical Wards.

Age.	1892	1893	1894	1895	1896	*Totals.*
0–5	—	1	—	—	—	1
5–10	1	—	2	1	7	11
10–15	1	—	3	1	5	10
15–20	2	1	—	7	14	24
20–30	1	2	3	4	18	28
30–40	—	1	2	2	7	12
40–50	—	2	1	—	1	4
50–60	—	—	—	—	1	1
Totals	5	7	11	15	53	91

TABLE SHOWING FREQUENCY OF ATTACK AT THE DIFFERENT AGES OF CASES ADMITTED TO ST. BARTHOLOMEW'S HOSPITAL, 1892–6.

Age.	*Medical Wards.*	*Surgical Wards.*	*Total.*	*Percentages.*	
0–5	—	1	1	·45	
5–10	10	11	21	9·5	
10–15	27	10	37	16·8	41·3
15–20	30	24	54	24·5	
20–30	37	28	65	29·5	
30–40	14	12	26	11·8	
40–50	8	4	12	5·4	
50–60	3	1	4	1·8	
	129	91	220		

The following table is taken from Treves' article on Perityphlitis in vol. iii of Clifford Allbutt's *System of Medicine*, and is placed here for comparison of the percentage of cases at the different ages. It was compiled from a total of 452 cases.

Age.	*Proportion of Cases per cent.*
5–10 years	10·8
10–20 „	40·7
20–30 „	29·0
30–40 „	11·5
40–50 „	4·6
Over 50 „	3·4

A Case of Tubal Pregnancy.

By T. STRANGEWAYS PIGG,
Demonstrator of Pathology in the University of Cambridge.

THE following notes on a case of tubal pregnancy speak for themselves. That the case is an unusual one there can be no doubt.

It will be noticed that the patient was under twenty, and with the exception of the changes due to the presence of the ovum, the uterus, the Fallopian tubes, and ovaries were quite normal.

I have been unable to find a similar case recorded, but no doubt a more careful search would be successful.

The patient, an unmarried girl æt. 19 years, "in perfect health," was seized one evening after returning from a short walk by a sudden desire to go to stool. Nothing was passed, but feeling faint and unwell the patient went to bed. A medical man was called in the next day. He found the patient in bed with a quiet pulse—normal temperature, but complaining of an uneasy feeling in abdomen. On examination the patient screamed at the slightest touch over the abdomen, though firm pressure gave no pain when her attention was distracted.

She had always been regular at her periods, and suffered no pain at these dates. The next period was due that day.

No further symptoms were noticed, and a simple purgative was prescribed and the patient ordered to remain in bed. During the afternoon and evening she fainted repeatedly, especially in turning on her right side, and early the next morning died, without having again been seen by her medical adviser.

I was asked to make a post-mortem examination, and the following is an abstract of my notes at the time:—The body was well nourished, but appeared very anæmic. On opening the abdomen a large quantity of blood and clot welled out, which had evidently been retained at considerable pressure. The whole peritoneal cavity was found to be full of blood and clot.

A careful examination was then made of the contents of the abdomen, and all the viscera were found to be healthy until the uterus was reached. It was then seen that the right Fallopian tube was distended by an oval swelling about the size of a walnut; this was situated one and a half inches from the uterus. At the upper and free border of the sac a small rupture was found, and this proved to be the source of the hæmorrhage which led to the patient's death. The sac was that of an extra-uterine pregnancy, and contained an ovum of about five weeks. The uterus and Fallopian tube presented the usual appearances of a tubal pregnancy of this age, but otherwise they were quite normal. They were carefully examined microscopically, and no evidence of any past or present inflammation could be discovered.

The right ovary contained a corpus luteum. All the other viscera were perfectly healthy.

Notes.

NEARLY one hundred past and present members of the Junior Staff, dressers, and "Fellowship" men have joined together to present a testimonial to Mr. James Berry on his retirement from the post of Surgical Registrar, as some slight acknowledgment of their high appreciation of all that he has done on their behalf during his tenure of that office. Mr. Berry has chosen an oil painting of the interior of St. Bartholomew the Great as the form which the presentation is to take.

* * *

IT appears that the list of Bart.'s men decorated with the V.C. is likely to receive yet another addition. According to the *British Medical Journal*, Surgeon-Captain William Selby, of the 1st Battalion 2nd Goorkhas, is to be recommended for this honour. He displayed great gallantry, standing over a wounded Goorkha and saving him when the enemy were almost upon him.

* * *

DR. COLLINS' old schoolfellows soon followed the example of his Hospital companions. He was entertained at dinner by former members of University College School at Frascati's on January 13th, Mr. Wolf Defries in the chair.

* * *

MR. W. E. N. DUNN has been appointed Junior Resident Anæsthetist in succession to Mr. F. H. Lewis, resigned.

* * *

IN connection with the paragraph in our last number

concerning the Gold Medal for Obstetrics at the London M.B., it is worth noting that this honour has fallen to Bart.'s fourteen times in the last seventeen years.

* * *

AT the suggestion of Dr. Waldo, Medical Officer of Health for Southwark, the Vestry have opened a receiving-house for the temporary reception of those whose houses are being disinfected for infectious disease. The families are accomodated for eight hours, and everything is found for them except food, which they, of course, have to provide. They are given baths and clean clothes while their own clothes are being disinfected. The idea is excellent, and might well be followed elsewhere.

* * *

THE *Guyoscope* is not dead after all; a second series has appeared, containing the obituary notices published by its contemporaries on its supposed demise! Some have referred to its Bob Sawyer-like character; but in this respect it has followed the example of Tom Sawyer, who had, we believe, the almost unique privilege of listening to his own funeral sermon.

* * *

THE ranks of our contemporaries has been still further recruited by *The Stethoscope*, being the Bristol Medical Students' Journal. With such a title it is rather a happy idea to head the column of hospital news with the words "On auscultation we hear."

* * *

ACCUSTOMED as we are to the curious forms of—enterprise, shall we call it, of the East End practitioner, it was a slight surprise to see recently a baby's feeding bottle with the name and address of a medical man stamped indelibly in the glass. Of course his name bore the prefix Dr., though the Medical Directory omits to credit him with the degree. The mother stated she bought the bottle at a "chemist's shop;" apparently her words were wiser than she knew.

* * *

THE next Examination for the Charles Murchison Scholarship in Clinical Medicine will be held at the Royal College of Physicians of London, on Monday, the 18th day of April, 1898, and following days. The Scholarship is open to any Student of Medicine who has been a registered Medical Student during a period of not less than four and not more than six years at a Hospital in London or Edinburgh recognised by the Royal College of Physicians of London or by the Medical Faculty of the University of Edinburgh, and whether holding a Medical qualification or not. The Examination will be conducted both orally and in writing, and will include—(*a*) examination of patients, with reports on their cases; (*b*) questions on pathology and treatment; and (*c*) examination on specimens. The Scholarship is of the value of Twenty Guineas, and is tenable for one year. Intending Candidates are required to send in their names to the Registrar of the Royal College of Physicians, Pall Mall East, London, not later than April 4th, with evidence of the duration of their Medical Studies from the Deans of their respective Schools.

* * *

SIR DYCE DUCKWORTH has been appointed Harveian Orator to the Royal College of Physicians.

* * *

DR. E. J. CAVE has been admitted a Member of the Royal College of Physicians.

* * *

MR. S. L. BOX and Mr. D. R. ROWLANDS have been granted the D.P.H. of the Royal College of Physicians and Surgeons.

* * *

MR. D. P. THOMAS, of Market Bosworth, has been placed on the Commission of Peace for the county of Leicester.

* * *

THE QUEEN'S SPEECH contains two references of interest to the profession. Many will be curious to see the proposed amendment of the Vaccination Law which will be recommended for the "earnest attention" of Parliament. We are glad to note that mention is made of legislation for a teaching University for London, even though qualified by the cautious remark "in case the time at your disposal should permit you to proceed" with it.

Amalgamated Clubs.

ASSOCIATION FOOTBALL CLUB.

BART.'S *v.* PEMBERTON.

Played at Winchmore on January 8th, and resulted in a defeat for the Hospital by 5 goals to 3. The ground was very slippery. At first Bart.'s played one short, and Pemberton quickly scored a goal. Bart.'s soon replied with one by Dawson; and again in the first half Ward scored for the Hospital, who crossed over with a lead of 2—1.

In the second half Pemberton played a much better game and pressed continuously, the Hospital team showing signs of want of condition after the Christmas vacation. So Pemberton scored 4 more goals, and Dawson did the only scoring for Bart.'s in the second half.

For Bart.'s Ward played a capital game, and Whitaker and Dawson were good, but the back division was decidedly weak.

Team.—C. Dix (goal); L. Orton, C. H. Turner (backs); E. H. Scholefield, C. G. Watson, N. E. Waterfield (halves); C. Dawson V. G. Ward, L. E. Whitaker, L. E. Hughes, H. N. Marrett (forwards).

ST. BART.'S *v.* CHESHUNT.

Played at Cheshunt on January 15th.

From the start Cheshunt pressed, and Barwell running through opened the scoring for Cheshunt, this proving to be their only point. The Hospital made a determined attack, but failed to score through weak shooting. The game continued even, and just before half-time Ward equalised with a good shot. From the re-start Cheshunt went off with a rush, and kept Butcher well employed. But suddenly a complete change came over the game, the Bart.'s forwards getting together and playing a magnificent game. And to the end of the game a continual bombardment of the Cheshunt goal was kept up, Bart.'s adding 5 more goals. Whitaker got the second, and Waterhouse the next two. A penalty resulted in a fifth from a shot by Whitaker, who later on added the sixth. Thus the Hospital won handsomely by 6 goals to 1.

This was by far the best game the Hospital have played this season, the forwards playing magnificently, and by their scoring in the second half fully atoning for weak shooting in the first.

At half Scholefield was very good, his tackling being quite first-rate; and at back Stone played a good game, while in goal Butcher was safe as usual.

Team.—H. H. Butcher, G. W. Stone, L. Orton, E. H. Scholefield, C. G. Watson, N. E. Waterfield, R. Waterhouse, J. A. Willett, L. E. Whitaker, V. G. Ward, H. N. Marrett.

ST. BART.'S *v.* BARNES.

Despite the fact that Whitaker, Willett, and Butcher were representing the United Hospitals at Cambridge, and Ward, Talbot, and Bostock were unable to play, the Hospital were able to bring off a victory against Barnes at Winchmore Hill on Saturday, January 22nd, by 2 goals to 1. Bart.'s were the first to score through O'Brien, but then though they pressed they failed to score through bad shooting. Before half-time Barnes equalised, and early in the second half Marrett scored the second goal for Bart.'s. The game remained unaltered to the end, when Bart.'s were left with a hard-earned victory.

Waterhouse, Murdoch, and O'Brien played well, and Scholefield as usual was the best of the back division.

Team.—G. Harland, G. W. Stone, L. Orton, E. H. Scholefield, C. G. Watson, N. E. Waterfield, M. G. Winder, R. Waterhouse, C. O'Brien, C. Murdoch, H. N. Marrett.

ST. BART.'S *v.* EASTBOURNE.

Played on the "Saffrons" ground at Eastbourne on Wednesday, January 26th, resulting in a win for the Hospital by 3 goals to 1. At the start Eastbourne pressed, and after a short time scored a goal in a rather unsatisfactory manner; one of their forwards pushing the ball through the goal with his hands. After this reverse, the Hospital quickly settling down attacked vigorously, and were soon rewarded with a goal, Willett scoring after a good shot from Pickering had struck the cross-bar and rebounded into play. Fast and even play was the order of the day, each goal being in danger several times until a penalty was given against Eastbourne, which Whitaker had no difficulty in negotiating, and half-time arrived with Bart.'s leading by 2 goals to 1. In the second half the Hospital had much the best of the game, never being seriously pressed, although Stanborough made some good runs, and sent in two or three good shots. Bart.'s scored once more, through Pickering, but several good chances were missed, as their shooting was not deadly. Just at the end Eastbourne made strenuous efforts to break through the Hospital defence, but were unsuccessful, and had to retire defeated by 3 to 1. For the Hospital Whitaker, Willett, and Pickering combined very well and did a lot of work, while Scholefield played his usual sound game at half, and Butcher was very safe in goal.

Team.—H. H. Butcher (goal); L. Orton and G. W. Stone (backs); E. H. Scholefield, A. N. Other and N. E. Waterfield (halves); H. N. Marrett, H. J. Pickering, L. E. Whitaker, J. Willett, and A. B. Artsman (forwards).

INTER-HOSPITAL SENIOR CUP TIE.

FIRST ROUND.—ST. BART.'S *v.* ST. MARY'S.

Played at Wimbledon on Friday, 28th January. The ground was in excellent condition, and no wind or sun to affect the game. Bart.'s won the toss; St Mary's kicking off and quickly getting together began with the best of the game, and made some brilliant attempts to score, which Bart.'s, who had started raggedly, only just managed to avert. Ward soon got away with a good run, unfortunately failing to score when close to goal. Mary's continued to press hard, but Bart.'s warmed to their work, and settling down to a steady defence very soon succeeded in shifting the play to their opponents' end. The game continued very equal, both sides putting in some hard shots and both defending well. At half-time, after some very vigorous play, neither side had scored; and although in this half Mary's had started so well, Bart.'s were gradually gaining the upper hand. From the kick-off Bart.'s, who were combining well, kept Mary's hard at work, and Marrett taking a neat pass from Ward made a dash down the line and put in a splendid shot from the corner, which Mary's goal-keeepr failed to stop. However, after a nasty fall Marrett succumbed to cramp and had to leave the field, which gave Mary's a decided advantage. Bart.'s had once more to assume a strictly defensive game, and were only able to make a few more unsuccessful attacks, in which Ward was chiefly conspicuous. The game all through was very fast and equal, and played in the usual cup tie form, though it was noticeable only one foul was given. No other scoring was done, and at the whistle the result stood Bart.'s 1, Mary's 0.

For Mary's, Vickers at back, Matthews at half, Leaming and Farquharson amongst the forwards played excellently. Altogether their team looked very fit, though Matthews and Gonin had bandaged hands.

For Bart's Orton, making no mistakes, was the backbone of the defence, and played a very steady and safe game, while too much cannot be said of the way Butcher kept goal and helped the backs. Scholefield, Ward, Marrett, and Talbot worked hard all through, but the rest of the team were certainly not up to their usual form. The teams were—

St. Mary's.—G. E. Peachall (goal); H. Vickers, R. Cruise, (backs); A. Sedgwick, H. Matthews, G. R. Cox (half-backs); H. E. Clarke, C. H. Farquharson, B. W. Gonin, J. Sharples, R. C. Leaming (captain) (forwards).

St. Bart.'s.—H. H. Butcher (goal); G. W. Stone, L. Orton (backs); A. H. Bostock, C. G. Watson, E. H. Scholefield (half-backs); H. N. Marrett, V. G. Ward, L. E. Whitaker (captain), J. A. Willett, J. H. Talbot (forwards).

RESERVES.

		Played at	*For*	*Agst.*
Wed. 8th Dec.	Holloway Sanatorium	Holloway	2	5
Sat. 11th „	Rahere Club	Winchmore Hill	5	2
Wed. 15th „	Royal Coll. of Science	Away	0	4
Sat. 22nd Jan.	Old Foresters	Forest School	1	4

INTER-HOSPITAL JUNIOR COMPETITION.

At a Committee meeting it was decided to enter for the Junior Inter-hospital Cup started this year, for which the following are the rules:

1. That there be a Cup for competition among the 2nd XI's of the Metropolitan Hospitals.
2. That the first round for the 2nd Cup be played after the first round of the Senior Competition.
3. A "second-eleven man" is one who is in his year, and as soon as he has played in the Senior Competition, he shall be ineligible for the Junior in that year.
4. The subscription shall be 10*s.*
5. The affairs shall be entirely under the management of the General Committee.
6. Only hospitals entering for the Senior Competition are allowed to enter for the Junior.

The following are the draws:

A. Guy's *v.* London.
B. St. Bart.'s *v.* St. Mary's.
St. Thomas's a bye.
B. *v.* A. St. Thomas's a bye.
B. or A. *v.* St. Thomas's.

A meeting was held at St. Mary's Hospital on January 14th to select a team to represent the United Hospitals *v.* Cambridge on Saturday, January 22nd. The following team was selected:

Goal: H. H. Butcher (St. Bart.'s); backs: J. Sharples (St. Mary's), P. A. Greene (London); half-backs: H. J. Pickering (St. Bart.'s), J. MacAlpine (Guy's), H. Fletcher (London); left wing: A. Hay (St. Bart.'s), L. E. Whitaker (St. Bart.'s); centre: G. P. Wilson (London); right wing: J. Willett (St. Bart.'s), L. Humphrey (Guy's). Reserves: L Orton (St. Bart.'s), back; H. N. Matthews (St. Mary's), half-back; R. C. Leaning (St. Mary's), H. A. Upward (London).

Owing to Cup Ties several men were unable to play; H. Vickers (St. Mary's), H. N. Matthews (St. Mary's), H. A. Upward (London), and R. C. Leaning (St. Mary's) playing for Pickering, MacAlpine, Hay, and Humphrey. The result was a defeat for the Hospitals by 7 goals to 2. Willett and Wilson scored for the Hospitals, and, despite the score, Butcher gave a good display in goal.

RUGBY UNION FOOTBALL CLUB.

We have received no news of the Club this month.

HOCKEY CLUB.

ST. BART.'S *v.* FINCHLEY 3RD.

Played at Winchmore Hill on October 23rd.

This resulted in the first win for the Hospital since hockey was started last year.

In the first half Butler scored from a scrimmage in front of goal, and Edwards sent the ball through just before half-time.

In the second half the ball was nearly always down their end; but

we could only beat their goal-keeper three times, Butler (twice) and Hallowes scoring with smart shots. Their goal was scored by one of our own men putting the ball through by mistake, the final score reading 5—1 in our favour.

Team.—A. Blank (goal); Nicholson, Jeaffreson (backs); Grenfell, Pollock, Parker (halves); Roberts, Butler, Muirhead, Edwards, Hallowes (forwards).

ST. BART.'S *v.* SOUTHGATE 2ND XI.

Played at Southgate on October 30th.

Soon after the start Southgate scored from a corner, but Muirhead equalised shortly afterwards. Another goal to them was cancelled by Butler, and at half-time the score read 2 all.

The second half was very even. Butler gave us the lead, which was kept till the last five minutes, when Southgate scored again from a corner, making a draw of a well-contested game. Score: 3—3.

Team.—Nicholson, Jeaffreson (backs); Grenfell, Parker, Boyd (halves); Johnson, Butler, Muirhead, Hallowes, Edwards (forwards).

ST. BART.'S *v.* EPPING.

Played at Epping on Saturday, November 6th.

Epping started off at a great pace, and during the first quarter of an hour scored 3 goals.

The second half was more keenly contested, and plenty of good opportunities were thrown away by bad shooting. Savill scored once for our opponents by a clever single-handed run, the result being 4—0 in their favour.

Team.—Nicholson, Jeaffreson (backs); Grenfell, Pollock, Parker (halves); Muirhead, Boyd, Johnson, Hallowes, Edwards (forwards).

Abernethian Society.

THE mid-sessional address was delivered on January 13th in the Medical Theatre by Dr. Lovell Drage. Mr. W. Langdon Brown, President, took the Chair at 8 o'clock. In the course of a few introductory remarks he welcomed Dr. Lovell Drage—an old house surgeon of Sir Thomas Smith's, and now coroner for the county of Hertford—on behalf of the Society, and called upon him to read a paper entitled "The Coroner's Court." The first part of the paper was taken up with interesting details of the historical side of the coroner's office, tracing its origin previous to A.D. 1194. He urged upon all members of the medical profession the importance of a knowledge of the working of the court, the coroner's office being one which provides protection for those signing death certificates and exonerating medical men from all blame if properly used. He thought that greater pains should be taken with regard to making post-mortems, and considered that the subject should receive greater attention in the training of medical schools. The question of juries almost always bringing in the verdict of temporary insanity in cases of suicide was discussed, the speaker thinking that the matter of insanity required some explanation, and that if a medical man is prepared to advance this theory he should likewise be prepared to back that statement up with facts.

A vote of thanks was proposed by Mr. Phillips and seconded by Mr. Tucker. This was carried with acclamation. The meeting then adjourned to the Library.

We regret the absence of the Nursing Staff on this occasion, which was as all the more unexpected as the secretaries received no intimation till the very morning of the meeting that such was to be the case. This was the first address, we believe, for at least two years from which they have been absent. Needless to say the success of the meeting suffered severely.

On January 20th the first ordinary meeting of the second half of the session was held in the Society's room; Mr. Hussey, President, in the Chair. Mr. Horder read a short paper on "Hypnotism," looking at the subject both from a medical and scientific point of view. An animated discussion followed, in which a visitor, Dr. Milne Bramwell, took a leading part.

On January 27th Mr. Langdon Brown, President, in the Chair, Dr. W. H. R. Rivers, Lecturer on Experimental Psychology at Cambridge, gave an address upon "Fatigue."

He spoke of the subject as it affected the individual, drawing a distinction between subjective and objective fatigue. He then explained and commented upon Professor Mosso's work in this department of science, describing the methods of examination employed, and pointed out the desirability of new methods. The experimental psychologists have lately been repeating and extending Mosso's experiments; but some of them, notably Professor Krepaline, have invented and largely used a method of numerical notation. This the speaker had employed himself; analysis of many work curves made out on the results of employing it had revealed the fact that besides fatigue there were many other factors to be taken into account in drawing up any satisfactory theory. Dr. Rivers then passed on to consider the relations of fatigue and medical therapeutics, touching on the action of drugs, the theories of immunisation and of resistance to disease, pointing out that this last observation was a contribution to the long-neglected study of temperament and constitution.

On February 3rd, Mr. Langdon Brown, President, in the Chair, Mr. Gladstone Clark read a paper on "Extra-uterine Gestation."

The speaker first dealt with the pathology of the disease, saying that it was now practically certain that the pregnancy was always tubal in the first place, and not peritoneal, discussing the various theories in relation to it. He then passed to the primary rupture and the cases in which the secondary rupture occurred, giving the reasons for believing that nature may cure the accident in such cases. The clinical features of the subject were then dealt with, the speaker dwelling for some time upon the question of the previous sterility in the majority of cases, the value of a history of amenorrhœa, and the character of the pain. This last symptom probably was due to three causes:

(1) Mechanical distension of the tube.
(2) Irregular contraction of the tube.
(3) Perimetritis.

Attention was given to the importance of not accepting the unsupported statement that a patient had miscarried. As this history is by no means infrequent in such cases, a bad mistake may sometimes be avoided by observing this precaution. Occasionally before rupture the enlarged tube may be felt in one or other posterior quarter of the pelvis, and the condition diagnosed with difficulty.

The importance of obtaining the certain signs of pregnancy before diagnosing an extra-uterine gestation was insisted upon; the sound should then only be used after consultation, and where it is absolutely necessary for diagnosis. The treatment was next discussed, the most favorable cases for operation, of course, being those in which the condition is diagnosed before rupture. Mr. Clark thought that the shock due to rupture is no contra-indication for laparotomy. Waiting was advised in those cases where after rupture the hæmatocele did not enlarge rapidly, but the medical attendant should always be prepared to operate on the shortest notice. The careful sponging away of all the old blood-clot was not advocated, the speaker believing that the general plastic peritonitis which sometimes supervened, not being septic, was due to irritation of an anæmic peritoneum by mechanical means.

The Rahere Lodge, No. 2546.

AN Ordinary Meeting of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant, Oxford Street, on Tuesday, January 11th, 1898, Bro. W. J. Walsham, F.R.C.S., the W.M, in the chair.

Bro. A. R. Kay, B.A.Oxon., of the Apollo University Lodge, No. 357, was elected a joining Member. Messrs. James Morrison and Edward Carnall were elected Members of the Lodge, and Dr. Morrison being present, was duly initiated into Freemasonry by the W.M.

Bros. Auden, Bill, Cripps-Lawrence, John Adams, Westbrook, and Trechmann, were raised to the third degree by the W.M. and W. Bro. Trollope.

A grant of £21 from the Lodge funds was made to the British Medical Benevolent Fund.

The brethren and their guests afterwards dined together.

An Ordinary Meeting of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant, Oxford Street. W., on the 8th inst., the W.M. Bro. W. J. Walsham in the chair. Bro. Morrison was passed to the second degree by W. Bro. Cripps; and Messrs. Edward Carnall and S. S. Hoyland having been elected members of the Lodge, were initiated into Masonry. Bro. G. W. Micklethwaite, of the Isaac Newton University Lodge, No. 859, was elected a joining member.

A vote of thirty guineas was made towards the forthcoming festival of the Masonic Institute for Boys.

Thirty-five members and their guests afterwards dined together, and the evening was enlivened by the music and recitations of Bros. F. W. Gale, Burns, Cripps, Robinson, and Tyard.

The Month's Calendar.

[Secretaries of Clubs, &c., are requested to co-operate in making this list as complete as possible by forwarding notices of forthcoming events to the Editor.]

FEBRUARY.

Wed. 16th.—R.U.F.C. *v.* East Sheen, at Richmond. Mr. Langton's Clinical Lecture at 2.45.
Thurs. 17th.—Abernethian Society at 8 p.m. Mr. Douglas on "Lymphadenoma."
Fri. 18th.—Dr. Gee's and Mr. Willett's duty. Dr. Church's Clinical Lecture at 1 p.m.
Sat. 19th.—R.U.F.C. *v.* Leicester, at Leicester. A.F.C. *v.* Salisbury, at Salisbury. R.U.F.C 2nd XV *v.* Upper Clapton, at Clapton.
Tues. 22nd.—Sir Dyce Duckworth's and Mr. Langton's duty. Semi-Final Inter-Hospital Rugby Cup Tie.
Wed. 23rd.—Mr. Langton's Clinical Lecture. R.U.F.C. *v.* Hampstead at Winchmore Hill.
Thurs. 24th.—Abernethian Society at 8 p.m. Dr. Emery on "The Action of Tobacco."
Fri. 25th.—Dr. Gee's Clinical Lecture. Dr. Hensley's and Mr. Marsh's duty.
Sat. 26th.—R.U.F.C. *v.* Rosslyn Park, at Old Deer Park. R.U.F.C. 2nd XV *v.* Templars.

MARCH.

Tues. 1st.—Dr. Brunton's and Mr. Butlin's duty. R.U.F.C. 2nd XV *v.* Forest School.
Wed. 2nd.—Mr. Marsh's Clinical Lecture.
Thurs. 3rd.—Abernethian Society at 8 p.m. Dr. Robinson on "Some points of interest concerning Gonorrhœa in Women."
Fri. 4th.—Dr. Church's and Sir Thomas Smith's duty. Sir Dyce Duckworth's Clinical Lecture. Final Inter-Hospital Cup Tie.
Sat. 5th.—R.U.F.C. 2nd XV *v.* Guy's Hospital 2nd XV, at Winchmore Hill.
Tues. 8th.—Dr. Gee's and Mr. Willett's duty.
Wed. 9th.—Mr. Marsh's Clinical Lecture. R.U.F.C. 2nd XV *v.* Royal School of Science, at Winchmore Hill.
Thurs. 10th.—Abernethian Society at 8 p.m. Mr. J. P. Maxwell on "Pyuria."
Fri. 11th.—Sir Dyce Duckworth's and Mr. Langton's duty. Dr. Hensley's Clinical Lecture.
Sat. 12th.—R.U.F.C. 2nd XV *v.* Ealing 2nd XV, at Winchmore Hill.
Tues. 15th.—Dr. Hensley's and Mr. Marsh's duty.

Volunteer Medical Staff Corps Ball.

THE members of the St. Bartholomew's Hospital Half-Company of the V.M.S.C. held their Second Annual Ball at the King's Hall, Holborn Restaurant, on Monday, January 24th, which seemed to be thoroughly enjoyed by over 200 subscribers and their friends.

The actual numbers present fell short of those attending last year, a fact which is to be regretted, as showing that the more general support by members of the Hospital anticipated was not forthcoming. In addition to the refreshment arrangements made for the previous occasion, a light supper was added, and it would appear that the alteration met with universal approval. Mrs. Walsham most kindly again officiated as the President of the Ladies' Committee, and received the guests.

The Committee were delighted to see so many of the Hospital Staff present, among whom may be mentioned Dr. Church, Sir Thomas Smith, Mr. Howard Marsh, Mr. Walsham, Dr. Herringham, and Dr. Calvert.

The band of the Royal Artillery furnished most charming music throughout the evening. So far as the ball itself was concerned, an unqualified success was obtained, but the financial aspect of the entertainment did not prove so encouraging. For this reason the Committee publish the balance-sheet, showing a considerable deficit entirely due to the small number of tickets sold among the students of the Hospital. In the face of such financial difficulty, it will be impossible for the Committee to again repeat their venture unless there are good reasons for believing that a more general and extended support will be afforded by the students themselves. At the same time the Committee will be only too pleased to receive suggestions in regard to the formation of a Committee which might have a wider field of influence among the various sects of students interested in recreation.

BALANCE-SHEET.

ST. BARTHOLOMEW'S HOSPITAL (V.M.S.C.) SECOND ANNUAL BALL, JANUARY 24TH, 1898.

Receipts.	£	s.	d.	*Payments.*	£	s.	d.
Subscriptions from sale of tickets ...	74	9	0	Holborn Restaurant, supper, &c. ...	71	5	8
Donations	3	13	6	Band	9	19	6
Deficit	15	9	10	Programmes, tickets, and printing ...	5	18	6
				Bouquets	1	15	6
				Tip to head waiter ...	1	0	0
				Badges, postage, telegrams, &c.	2	18	2
				Committee expenses	0	15	0
	£93	12	4		£93	12	4

Audited and found correct,
A. J. W. Wells,
H. G. McKinney, } *Hon. Auditors.*

Reviews.

ROUGH NOTES ON REMEDIES, by Wm. Murray, M.D., F.R.C.P. Lond., 2nd edition. (London, H. K. Lewis, 1897, price *3s. 6d.*)

Dr. Murray's main thesis is stated clearly in his preface: "We have stood almost still too long, bewildered by the profusion of new remedies presented to us by the pharmaceutists, and striking almost blindly with new-fangled remedies, while the old trusty swords of our ancient armoury lie rusting on the shelf." He therefore urges a more systematic observation of the effects of well-known drugs. A glance at his table of contents shows that he sticks to his text—arsenic, belladonna, mercury, and nitrate of silver being the drugs of which he treats.

The book is most refreshing. Dr. Murray is an enthusiast, and he refers the modern scepticism concerning the efficacy of drugs to the use of the right remedy under unsuitable conditions, in inadequate doses, or in unfortunate combinations. "I, for my own part," says he, "have an undying, nay, an increasing vital faith in the virtue of medicines." He certainly has the courage of his convictions, for we read of 15 minims of Liquor Arsenicalis three times a day, 40 minims of tincture of belladonna every two hours, and *80 grains* of calomel for a single dose. Assuredly if these heroic doses be necessary for success, we moderns are but trifling with the trusty weapons of the ancient armoury. We shrink from wielding the sword of Ulysses. It has been said that it is never worth a man's while to give a dose which will imperil his night's rest, and personally we should sleep but ill after prescribing such. Nightmare visions of arsenical neuritis, of belladonna delirium, of acute mercurial poisoning, would haunt us, and we should arise determined to confine our therapeutical enterprise to Haustus Flavus.

But, seriously, these notes are well worth reading: they are thoroughly suggestive even where entire acquiescence cannot be given; they bear the marks of clinical experience; they force us to reconsider our position in many particulars. It is only too true that many modern text-books relegate treatment to a few lines at the end of a chapter, while devoting pages to points of pathology often obscure. But our patients expect to be cured: they do not care merely to be regarded as interesting cases; and it is a melancholy

fact that an old-fashioned practitioner who employs only a few drugs, but knows them and their combinations practically, will succeed in effecting a cure where a man well versed in motor points and counter-staining will cut but a sorry figure.

SCHOOL HYGIENE IN ITS MENTAL, MORAL, AND PHYSICAL ASPECTS, by J. KERR, M.A., M.D., D.P.H.Cantab.

This excellent little book is a reprint from the *Journal of the Royal Statistical Society* of Dr. Kerr's Prize Essay for the Howard Medal of the Society. In his position of Medical Superintendent to the Bradford School Board, Dr. Kerr has had exceptional opportunities for the study of his subject, and has collected some valuable facts and statistics. After giving a general historical account of the origin of the present educational system, Dr. Kerr plunges boldly into the consideration of the effects of the aggregation of large numbers of children in Board schools, and deals in a masterly way with the elaborate and extensive precautions necessary to preserve the individual health, and to prevent the spread of disease accidentally introduced. From statistics of death-rates at school ages before and since the Education Acts dealing with accidents, measles, whooping-cough, scarlatina, diphtheria, smallpox, and phthisis, the general conclusion is arrived at that increasing school attendance does not act harmfully. In the case of phthisis, however, an increased death-rate appears to be associated with increased school attendance. From statistics of notifications of infectious disease, there does not appear to be any evidence for England and Wales that school attendance is any considerable factor in disseminating diphtheria. The importance of proper organisation of the schools is insisted upon, and particularly that of warming and ventilation, which is described as "the most urgent and pressing question at present in school hygiene." Many valuable statistics and much useful information are given by Dr. Kerr on this point. Lighting of schools is next dealt with, after which Dr. Kerr treats of the growth, hearing, and vision of school children, in an elaborate system of statistics, and several interesting results are arrived at: thus it is found that the percentage of defective vision "diminishes from year to year with age, and from class to class as we ascend in the school." The importance of such details as the height and character of the seats and desks is gone into. Finally, the vexed and important question of how to deal with special cases of intellectually defective children and the deaf and blind is discussed. Altogether we congratulate Dr. Kerr on his book.

WILLIAM HARVEY, by D'Arcy Power, F.S.A., F.R.C.S. ("Masters of Medicine" Series, London, Fisher, Unwin, and Co., 1897, price 3*s.* 6*d.*)

In this excellent biography Mr. D'Arcy Power has evidently closely followed Boswell's maxims with admirable results. By copious use of contemporary documents he has drawn a vivid picture of our Hospital's greatest physician and his surroundings. Born in 1578 and dying in 1657, William Harvey lived through some stirring years of our national history; associated in turn with the Universities of Cambridge, Padua, and Oxford, he was provided with the best available academic training. At Cambridge Caius had just founded the study of anatomy on a sure basis; at Padua the science had been greatly developed by Vesalius and his successor Fabricius; while at Oxford, in his maturer years, Harvey was enabled to escape from the turmoil of the Civil Wars, and quietly trace the development of the egg with Bathurst at Trinity. Long may the ancient universities continue thus to afford a secure retreat for the scholar. But the scholar can seldom entirely escape from strife that rends the state; Archimedes paid the penalty with his life, and Harvey was not scatheless. The mob broke into his rooms at Whitehall, scattering his notes on post-mortem examinations, embryology, and comparative anatomy. The imagination conjures up the losses that Science has sustained from the destruction of her sibylline leaves, whether by the vandalism of the mob, by the gambols of a pet dog, or by the impious hand of Sir Everard Home. What discoveries, we wonder, are hidden in those lost papers of Harvey, Newton, and Hunter? There is reason to hope, however, that some of Harvey's writings may be found again; so lately as 1888 Dr. Norman Moore discovered a fragment.

To the Bart.'s man the chief interest of the book lies in the narration of Harvey's association with this ancient Hospital, to which he became physician in 1609. The former relative status of the physician and surgeon is impressed upon us by the fact that even till Abernethy's day no surgeon could prescribe anything beyond a blue pill or a black draught, unless the prescription was counter-signed by a physician. Even in surgical matters they had not a free hand, for it was ordained in Harvey's time "that no chirurgeon or his man do trepan the head, pierce the body, dismember or do any great operation on the body of any, but with the approbation and by the direction of the doctor." A side-light is thrown upon these humiliating restrictions by the application of a certain surgeon to be excused from attending "anatomies" on the plea that he now confined his attention to shaving and selling silk! But the Barber-Surgeons' Company possessed some power, as Harvey discovered to his cost when he failed to diagnose a fractured skull, and did not call in a surgeon. This error of his should be a consolation to a house surgeon pilloried in the *Star*, or riddled by the questions of an "intelligent" juror.

Arduous as the duties of the Censors of the Royal College of Physicians may be to-day, they are at least spared the task that then fell on them of visiting the various apothecaries' shops and investigating their stores. The report on the Diascordium and the Venice treacle supplied in several shops is very unflattering; but doubtless their therapeutic activity was quite as great as that of approved samples.

Space fails us to comment on the many points of interest raised by Mr. Power's book, but we must notice, in conclusion, the essential modernity (to use a cant phrase) of the researches which led to Harvey's great discovery of the circulation of the blood. The clear logic, the direct appeal to experiment, the arguments derived from comparative anatomy and embryology, mark him out as a true father of many of our modern methods, and for all time as a man of commanding genius.

CATECHISM SERIES, Surgery, Part VI. (Edinburgh, E. and S. Livingstone, price 1*s.*)

If a work of this type be really needed, it is the strongest possible argument for the necessity of a severer entrance examination for medical students. We always like to say anything that can be said in praise of a book, and must therefore bring this review to a hasty conclusion.

Obituary.

HENRY COVERNTON SELBY, M.A., M.B., B.C.(Cantab.), M.R.C.S., L.R.C.P.

WE much regret to announce the sudden death of H. C. Selby at the Napier Hotel, Poona, on January 2nd, from heart disease. He had only just reached India for special plague duty, and his serious condition was apparently unsuspected; the fact remains that he had aortic regurgitation. The night before he was seen by his Bart.'s colleagues shortly before midnight in his usual health; Mr. Littler Jones was called at a quarter to seven in the morning to see him, as he had become alarmingly ill, and in spite of all that could be done he died at half past eight.

At his funeral there were present two Bart.'s nurses and no less than four Bart.'s men. His cousin, Prof. Covernton, the only relative he had in the country, arrived from Bombay in time to be present. Among the flowers placed on his grave were wreaths from the Bart.'s men now on plague duty, the Poona Plague Committee, the nurses at Valentine Lodge, and other friends.

The deceased entered Downing College, Cambridge, in 1890, of which foundation he became a Scholar; he graduated in the First Class of the Natural Sciences Tripos in 1893, and subsequently joined this Hospital. He took his Diploma and M.B. in due course, but was soon after laid aside for a time with typhoid fever. This was said to have left him with a dilated heart, and he went for a voyage

to America, from which he returned apparently in good health. The fact that he had a serious organic lesion of the heart was, as we have already said, unknown till the last few minutes of his life. And thus is cut short a career from which past performances had led us to expect much.

DRUCE JOHN SLATER, M.D.Lond.

On Saturday, the 29th of January last, occurred the untimely death of an old St. Bartholomew's man, popular in his time as an athlete and as a trusty comrade—Druce John Slater. He was out shooting when, through some accident, his gun discharged and lodged the contents of both barrels in his chest. His death was almost instantaneous.

Druce Slater was born in November, 1856, and was consequently in his forty-second year. He entered the Hospital in 1878, became M.B.Lond. and M.R.C.S. in 1883, and held in succession the posts of Obstetric House Physician to the late Dr. Matthews Duncan; Clinical Assistant to the Hospital for Consumption, Brompton; and House Surgeon to the East London Hospital for Children, Shadwell. After travelling abroad with a shooting party he finally settled down to general practice in South Kensington, where he very soon made for himself a large circle of acquaintances, both friends and clients; for Slater was not only a sound doctor, he was also a genial and entertaining companion. In 1888 he passed the examination for the M.D.Lond. His practice went on increasing until Christmas, 1896, when he fell a victim to influenza, after successfully withstanding its attacks since 1889. But though stoutly built and possessed of energy, which seemed to many of his friends inexhaustible, the prolonged and arduous work immediately preceding his illness left him in a condition not the most favorable to resist what we are all now well acquainted with as one of the worst after-effects of influenza, profound nervous depression. And in order to recover from this he was advised abroad. He visited Jersey and the Canary Islands, and was greatly benefited by a tour through South Africa. On his return to England in September of last year he rested at the sea-side for a month, and in October resumed his practice. Friends and patients all were delighted to see the marked improvement in his state, for his buoyancy of spirits and his untiring zeal for the welfare of others had made him a general favourite. But not only did he win the affection of his friends and the confidence of his brother practitioners, he gained also the esteem and respect of his patients by his assiduous attention to their well-being in time of illness. When work was to be done he never spared himself, nor did he ever grudge his night's rest spent at the bedside of the sick. As I have heard it remarked by one of his grateful patients, "never did anyone spare himself so little when anxious and critical work was to be done in his profession as Dr. Slater." And this feeling in which he was affectionately held found itself a vent in the great number of sorrowing inquiries at the first rumour of his sudden death, and the numerous and beautiful wreaths that attended him to his last resting-place. Druce Slater's temperament was peculiarly sensitive; he loved to be always doing, and was full of generous self-sacrifice for others' good. His memory will not fade amidst his friends, and he will be remembered at St. Bartholomew's as being one of the first, if not the first, to fight the battles of the Junior Staff.

New Productions.

D. C. L. MALT EXTRACT.—Messrs. T. B. Browne, Limited, have forwarded to us a highly palatable Malt Extract prepared by the Distillers' Company, Limited, Edinburgh, which we should think could hardly disagree with the most delicate digestions.

St. Bartholomew's Hospital Christian Association.

MEETINGS have been arranged for the months of February and March in the Inquest Room at 5 p.m. The following speakers have promised to be present:

Feb. 3rd.—T. Tatlow, Esq.
" 10th.—H. W. Maynard, Esq.
" 17th.—A. Mercer, Esq.
" 24th.—W. R. Moore, Esq., B.A.
March 3rd.—A. E. W. Gwyn, Esq.
" 10th.—Rev. A. Rouse, M.A.
" 17th.—Bible Reading.

A prayer meeting is held daily (Saturdays excepted) in the vestry of the church at 1.0 to 1.10 p.m.

C. A. S. RIDOUT, *Hon. Sec.*

Appointments.

BUMSTED, H. J., B.A.(Cantab.), M.R.C.S., L.R.C.P., appointed House Surgeon to the Beckett Hospital, Barnsley.

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CALVERLEY, J. E. G., M.B., B.S.(Lond.), M.R.C.S., L.R.C.P., appointed Surgeon to P. & O. ss. Valetta.

* * *

HALL, A. J., M.B., B C.(Cantab.), M.R.C.P.(Lond.), M.R.C.S., has been reappointed an Honorary Physician to the Sheffield Royal Hospital.

Examinations.

CONJOINT BOARD.—M.R.C.S., L.R.C.P.—The following have completed their examinations and taken their diplomas:—J. W. Milne, J. L. Morris, A. G. Tolputt, W. B. Parsons, C. L. Fort, W. A. Bramsdon, R. N. Geach, E. A. Weber, R. Hatfield, E. S. E. Hewer, N. H. Joy, R. H. Lloyd, H. G. Tymms, A. O. Way, C. V. Knight, B. J. Collyer. *Chemistry and Physics.*—T. H. Fowler, G. Hughes, J. K. N. Marsh, H. M. H. Melhuish, G. W. Miller, A. C. Young. *Practical Pharmacy.*—F. H. Ellis, R. J. Hanbury, F. G. Richards, G. A. W. Spear. *Elementary Biology.*—J. G. de G.

Best, E. S. Ellis, L. U. Geraty. *Anatomy and Physiology.*—E. B. D. Adams, G. E. Cathcart, D. C. O'C. Finigan, E. C. Hepper, J. W. Robertson, E. D. Smith, F. E. Taylor.

SOCIETY OF APOTHECARIES.—*Medicine* (*Section I*) *and Forensic Medicine.*—J. B. Cautley.

Correspondence.

To the Editor of the St. Bartholomew's Hospital Journal.

THE ROUTINE DOUCHING OF THE PUERPERAL UTERUS.

SIR,—Since reading Dr. James Morrison's paper in the JOURNAL of June last, I have scanned each succeeding issue for some criticism of his advocacy of routine douching of the puerperal uterus. I am glad to see that in the December issue Dr. Robinson has opened the ball.

Dr. Robinson deals so skilfully with the question from a scientific point of view that I cannot hope to add anything of value to what he has said from that standpoint.

My first comment on reading Dr. Morrison's paper was that in existing conditions of general practice, a routine douching of confinement cases on the third or fourth day would be so unusual that but few patients would consent to it, and of these still fewer would give the practitioner an opportunity of attending them in future confinements. I make this comment with bated breath; it is, I fear, too utilitarian to carry weight with those whose present happy aim is science apart from shekels. However, to any Bart.'s man who intends to douche all and sundry of his confinement cases willy-nilly on the third or fourth day, I respectfully say, "for the sake of your practice, don't!" Why, on the third day they "negotiate their last fence," take their dose of oil, and that being done with consider themselves "out of the wood," and take the doctor's future visits as mere milestones on the road to recovery. Woe betide the man who disturbs them from their comfort at this time in order that (to quote Dr. Morrison) "an intra-uterine douche may be given, and the uterus thoroughly washed out."

If, then, one is imbued with Dr. Morrison's views, and must for conscience sake carry them out, one risks becoming a martyr in the cause; all the more reason for making certain that the cause is a good one, and I for one am grateful to Dr. Robinson for showing that it is not. I can speak only from my own knowledge of between two and three hundred cases occurring in general practice in the country. Of these many were "B.B.A's" (owing to distance) attended by well-meaning but terribly septic country women, and in many more the sanitary conditions were of the worst, the cesspools about here being generally under the bedroom window and next door to the well.

I cannot pretend to any exact notes of the cases that have run a normal course, and it may be that of these (to quote Dr. Morrison) "every woman was at about the end of the first week slightly sapræmic or septic," but I doubt it. That it was so in a few cases I know, but I also know that a judicious purge rendered the temperature normal for good. With the four abnormal cases I can claim a more intimate acquaintance, and these, of course, involved the use of the douche.

By abnormal cases I mean, of course, those which were abnormal during the puerperal period, not those abnormal during labour. To give brief details:

1. Primipara æt. 17 (B. B. A.). I examined placenta and suspected retained membranes. On the fourth day temperature 101°. Quinine prescribed. On morning of fifth day temperature 102°. On evening of fifth day temperature 104°. I gave perchloride douche and removed decomposing membranes. The temperature dropped to normal, and subsequent recovery was uninterrupted.

2. Multipara. When first called to the case the os was practically undilated, and the distended cervix protruded from the vagina into a particularly septic bed (exactly as described by a correspondent writing from Jamaica to the *British Medical Journal* in June, 1896). Delivery was afterwards effected naturally, during my short absence from the house. The patient afterwards developed general septicæmia and died. Douches were given regularly from the time of the first rise of temperature.

3. Multipara with continually raised temperature from fourth day. In spite of constant douches she developed pelvic abscess, which ended in complete convalescence under other hands.

4. Multipara. Good hygienic conditions, but a first-rate trained nurse. Constant elevation of temperature at some period of the day from fourth to tenth day, scarcely ever above 100°. On tenth day, at midday, I gave a perchloride douche 1—4000, which would have been given earlier, but the patient was very much opposed to it. During the afternoon the patient had abdominal pain, which increased to the great alarm of both patient and nurse. I saw her at 8 p.m., and found her in intense abdominal pain, with the legs drawn up. The temperature was 102°. Fortunately twenty grains of antipyrin brought down the temperature to 99°, and next morning it was normal. The recovery was afterwards rapid and uninterrupted.

When one sees case after case run on to an uninterrupted recovery under the most adverse conditions, even when, as in cases B.B.A., such ordinary precautions as clean hands, let alone disinfected hands, have been absent, how can one possibly agree with Dr. Morrison that nature "probably" meant well, but that she is powerless to prevent the noxious germs from rushing up to happy hunting-grounds on the placental site?

I cannot recollect this spirit in the teaching of Dr. Matthews Duncan. I rather remember his maxim that "meddlesome midwifery is bad midwifery."

The value of the douche as a remedy rather than a routine is very great, of course, and one word in this connection respecting Case 4 mentioned above.

In this case the douche was distinctly indicated, and eventually completely successful, but it caused some of those alarming symptoms which Dr. Morrison says "are mentioned in books as having occurred," and of which Dr. Robinson gives such timely warning.

I would submit that the puerperal state is a natural state, and that the douche is one of our many means of assisting nature when she requires assistance; but that as a routine treatment in every case on the third or fourth day it is unnecessary and risky.

Yours faithfully,

LAURENCE A. WINTER, M.R.C.S., L.R.C.P.

Chartham, Kent; *Dec. 15th*, 1897.

Births.

HENSTOCK.—On December 24th, 1897, at Viña del Mar, Chile, the wife of J. L. Henstock, M.R.C.S., L.R.C.P., of a son.

ROBINSON.—On January 25th, at Killieser Avenue, Streatham Hill, the wife of Louis Robinson, M.D., of a daughter.

SKIPWORTH.—On January 28th, at the Terrace, Gravesend, the wife of P. L. G. Skipworth, M.R.C.S.(Eng.), of a son.

Marriages.

GILLIES—WILLIES.—On January 12th, at St. Augustine's, Flintham, by the Rev. J. H. Heath, M.A., Sinclair Gillies, M.A., M.D., son of the late Mr. Justice Gillies, of Auckland, N.Z, to Annie, younger daughter of John Willies, Flintham, Notts, late of Ossington Grange, Newark.

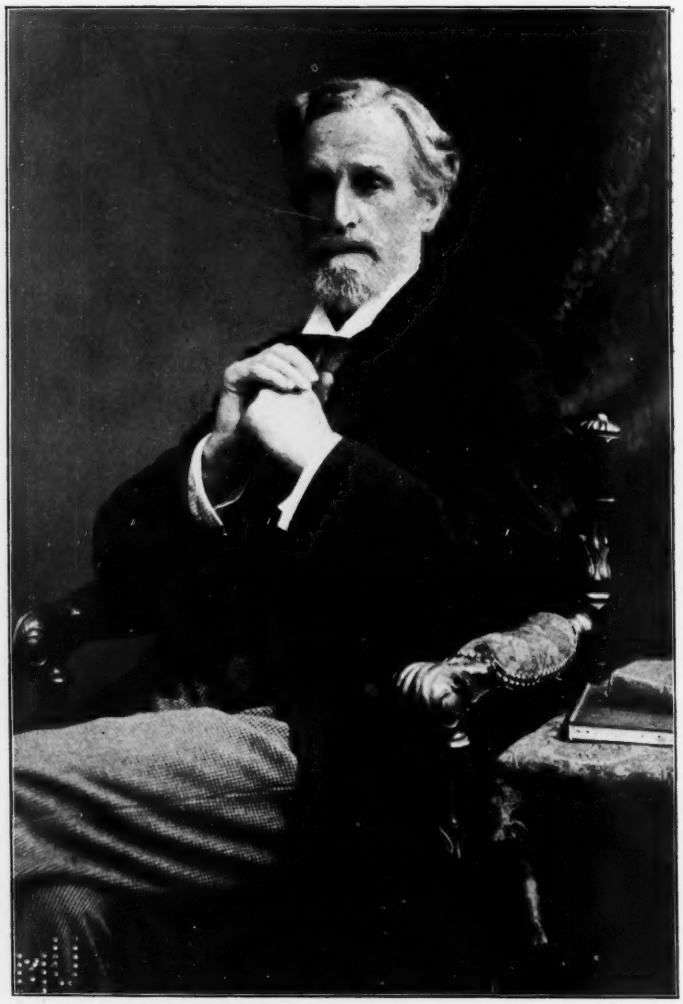
MAUND—NODING.—January 26th, at the Pro-Cathedral, Kensington, by the Rev. Septimus Andrews, M.A., O.S.C., assisted by the Rev. Michael Fanning, John, eldest son of the late John Maund, Esq., J.P., D.L., of Ty Mawr, Brecon, to Clare, only daughter of the late Thomas Henry Noding, Esq., of Trinidad, W.I.

Deaths.

SELBY.—On January 2nd, at the Napier Hotel, Poona, Henry Covernton Selby, M.A., M.B., B.C.(Cantab.), M.R.C.S., L.R.C.P., aged 30.

SLATER.—On January 29th, at Temsworth, Bedfordshire, Druce John Slater, M.D.(Lond.), M.R.C.S., L.R.C.P., of Courtfield Road, South Kensington, aged 41.

ACKNOWLEDGMENTS.—*St. Thomas's Hospital Gazette, Guy's Hospital Gazette, London Hospital Gazette, The Stethoscope, The Sphygmograph, The Dentist, The Student, The Nursing Record, St. Mary's Hospital Gazette, The Guyoscope, The Hospital, St. George's Hospital Gazette.*



Thomas Smith.